NOTICE

TO ALL ASYLEE AND REFUGEE FOLLOWING TO JOIN (FTJ) APPLICANTS

PLEASE SUBMIT THE FOLLOWING **PASSPORT PHOTO** FORMATS:

1. EIGHT (8) FRONT VIEW (BLACK AND WHITE)
2. TWO (2) RIGHT VIEW (BLACK AND WHITE)
3. TWO (2) FRONT VIEW (COLORED)

ALL PHOTOS MUST BE ON PLAIN WHITE BACKGROUND

NOTE: POLAROID AND INSTANT PHOTOS ARE NOT ACCEPTABLE.

G-646

U.S. Department of Justice
Immigration and Naturalization Service

Sworn Statement of Refugee Applying for Admission into the United States

Authority. The Authority to collect this information is contained in 8 U.S.C. 1157. Failure to provide all requested information could delay the final decision or result in denial of your request. The information collected will be used to make a determination on your application for admission. It may, however, be provided to other U.S. government agencies.

Penalties. If you knowingly and willfully falsify or conceal a material fact or submit a false document with this application, you will face penalties provided by law and may be subject to criminal prosecution.

Public Reporting Burden. Under the Paperwork Reduction Act (5 U.S.C. 1320), a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. We try to create forms and instructions that are accurate, can be easily understood, and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. The estimated average time to complete and file this application is 20 minutes per application. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Immigration and Naturalization Service, 425 I Street, N.W., Room 5307, Washington, DC 20536. *(Do not mail **your** completed application to this address.)*

All Applicants For Refugee Status Must Establish That They Are Admissible.

Name	A

Please answer the following questions truthfully. Check the appropriate box below. Answering "Yes" will not necessarily exclude you from admission to the United States. If it is determined that your admission into the United States presents a foreign policy danger to the United States, you may be found inadmissible. If you answer "Yes" to any of the following questions, please provide an explanation on the reverse side of these pages.

Yes	No	
☐	☐	**1. Have you ever been arrested, or have you ever committed, or helped someone else commit, any crimes?**
		If no, proceed to 2 below. If yes, have you ever:
☐	☐	a. knowingly committed any crime (excluding traffic violations) for which you have not been arrested?
☐	☐	b. been arrested, cited, charged, indicted, fined or imprisoned for breaking or violating any law or ordinance excluding traffic violations?
☐	☐	c. been the beneficiary of a pardon, amnesty, rehabilitation decree or other act of clemency or similar action?
☐	☐	d. exercised diplomatic immunity to avoid prosecution for a criminal offense in the United States?
☐	☐	e. illicitly trafficked (illegally transported, traded, dealt or sold) in any illegal narcotic or other controlled substance, or knowingly assisted, abetted or conspired in the illicit trafficking of any such substance?
☐	☐	f. engaged in any unlawful commercialized vice, including, but not limited to, illegal gambling?
☐	☐	g. knowingly encouraged, induced, assisted, abetted or aided any alien to try to enter the United States illegally?
☐	☐	h. within the past 10 years been a prostitute or procured anyone for prostitution?

Name: _____ File Number: _____

Yes	No	
☐	☐	**2. Have you ever been to the United States?** **If no, proceed to 3 below. If yes, have you ever:**
☐	☐	a. been subject to deportation or removal from the United States?
☐	☐	b. voted illegally in the United States?
☐	☐	c. been a citizen of the United States who has renounced that citizenship to avoid taxation?
☐	☐	d. left the United States to avoid being drafted into the United States armed forces?
☐	☐	e. been subject to a civil document fraud final order for violating section 274C of the Immigration and Nationality Act of the United States?
☐	☐	**3. Are you now withholding custody of a United States citizen child outside the United States from a person granted custody of the child?**
		4. Have you ever:
☐	☐	a. engaged in, conspired to engage in, or incited, sabotage, kidnapping, assassination, hijacking, or any other form of terrorist activity?
☐	☐	b. solicited membership or funds for any person or organization that has ever engaged in or conspired to engage in sabotage, kidnapping, assassination, hijacking, or any other form of terrorist activity?
☐	☐	c. provided support, including, housing, transportation, communications, funds, documents, weapons or training for any person or organization that has ever engaged in or conspired to engage in sabotage, kidnapping, assassination, hijacking, or any other form of terrorist activity?
☐	☐	d. been a representative or member of a terrorist organization or a member of a group which endorses terrorist activity?
☐	☐	e. [If married] Has your spouse ever engaged in terrorist activity or been a member of a terrorist organization?
☐	☐	f. [If between 14 and 21] Has your parent ever engaged in terrorist activity or been a member of a terrorist organization?
		5. While in the United States, do you intend to engage in:
☐	☐	a. espionage?
☐	☐	b. terrorism or any activity a purpose of which is opposition to, or the control or overthrow of the Government of the United States, by force, violence or other unlawful means?
☐	☐	c. any activity to violate or evade any law prohibiting the export from the United States of goods, technology or sensitive information?
☐	☐	d. polygamy (simultaneous marriage to more than one spouse)?
☐	☐	e. prostitution?
☐	☐	**6. Have you ever been a member of, or in any way affiliated with, the Communist party or any other totalitarian party?**

Name: _____ File Number: _____

Yes	No		
☐	☐	7.	**[Where Applicable] Did you, during the period March 23, 1933 to May 8, 1945, in association with either the Nazi Government of Germany or any organization or government associated or allied with the Nazi Government of Germany, ever order, incite, assist or otherwise participate in the persecution of any person because of race, religion, national origin or political opinion?**
☐	☐	8.	**Have you ever ordered, incited, assisted in or participated in the harm of any other person because of the person's race, religion, nationality, ethnic origin or political opinion?**
			If no, proceed to 9 below. If yes, have you ever:
☐	☐		a. engaged in genocide?
			b. as a foreign government official at any time in the preceding 24 month period been responsible for:
☐	☐		i. prolonged, arbitrary, or secretive detention or abduction of a person or persons with the purpose of restricting their religious freedom, beliefs or activities?
☐	☐		ii. torture or cruel, inhuman, or degrading treatment or punishment of a person or persons with the purpose of restricting their religious freedom, beliefs or activities?
☐	☐		iii. any other flagrant denial of the right to life, liberty or the security of a person or persons with the purpose of restricting their religious freedom, beliefs or activities?
☐	☐	9.	**Have you, by fraud or willful misrepresentation of a material fact, ever sought to procure, or procured, a visa, other documentation, entry into the United States or any other immigration benefit?**
☐	☐	10.	**Are you a narcotics abuser or addict?**

I, the undersigned, swear or affirm under penalty of perjury under the laws of the United States of America that this application, and the evidence submitted with it, is all true and correct. I understand all the foregoing statements, having asked for and obtained a translation or explanation of every point that was not understood or clear to me.

_____ _____

Signature of Applicant Date

Subscribed and sworn to (Affirmed) by the above named applicant before me

Location: _____ Date: _____

Interpreter:	INS Officer:
_____ Signature	_____ Signature
_____ Print Name	_____ Print Name

UNITED STATES DEPARTMENT OF JUSTICE
IMMIGRATION AND NATURALIZATION SERVICE

AFFIDAVIT RE RELATIONSHIP FOR REFUGEE/ASYLEE APPLYING FOR ENTRY INTO THE UNITED STATES

Lagos, Nigeria

Alien Registration No. _____

I, _____ being duly sworn depose and say:
(Name of Applicant)

I am the _____
(Specify Relationship)

of _____
(Name of Relative in United States)

residing at: _____
(Address of Relative in United States)

who has the following status in the United States:

- ☐ United States Citizen
- ☐ Lawful Permanent Resident Alien
- ☐ Refugee in the United States
- ☐ Asylee in the United States
- ☐ Other (Explain)

_____
(Complete and True Signature of Applicant)

Subscribed and sworn to me by the above-mentioned applicant at Lagos, Nigeria on _____

_____
(Signature and Name Stamp of Officer)

c:docs/ivdocs/asylee2.doc

OMB No. 1615-0008; Expires 05/31/09

Department of Homeland Security
U.S. Citizenship and Immigration Services

G-325C, Biographic Information

(Family Name)	(First Name)	(Middle Name)	☐ Male ☐ Female	Birth Date (mm/dd/yyyy)	Citizenship/Nationality	File Number A
All Other Names Used (Including names by previous marriages)			City and Country of Birth		U.S. Social Security # *(If any).*	

	Family Name	First Name	Date, City and Country of Birth (If known)	City and Country of Residence
Father				
Mother (Maiden Name)				

Husband or Wife (If none, so state)	Family Name (For wife, give maiden name)	First Name	Birth Date (mm/dd/yyyy)	City and Country of Birth	Date of Marriage	Place of Marriage

Former Husbands or Wives (If none, so state) Family Name (For wife, give maiden name)	First Name	Birth Date (mm/dd/yyyy)	Date and Place of Marriage	Date and Place of Termination of Marriage

Applicant's residence last five years. List present address first.

Street and Number	City	Province or State	Country	From Month	From Year	To Month	To Year
						Present Time	

Applicant's employment last five years. (If none, so state.) List present employment first.

Full Name and Address of Employer	Occupation (Specify)	From Month	From Year	To Month	To Year
				Present Time	

Applicant for Refugee Status

If your native alphabet is in other than Roman letters, write your name in your native alphabet below:

Date _____ (Signature of Applicant) _____

Penalties: Severe penalties are provided by law for knowingly and willfully falsifying or concealing a material fact.

Applicant: **Be sure to put your name and Alien Registration Number in the box outlined by heavy border below.**

Complete This Box (Family Name)	(Given Name)	(Middle Name)	(Alien Registration Number)

United States of America
Diplomatic Mission to Nigeria

Assistant Inspector General
Criminal Investigation Department
Nigerian Police Force
Alagbon Close
Ikoyi, Lagos

Dear Sir:

The bearer is applying for a visa at our office. If you would be kind enough to issue him/her a certificate of no conviction if s/he has no record in the Central Criminal Registry, we would very much appreciate it.

Thank you for your time.

Sincerely,

Consular Officer
U.S. Consulate General
Lagos, Nigeria

To the applicant:

Please follow these instructions to facilitate the issuance of your Nigerian Police Clearance Certificate.

1. Submit your passport in person to the Nigerian Police Service Commission at Alagbon Close, Ikoyi Lagos.

2. Pay the required fee and take the receipt to the Office of the Inspector General at Alagbon Close, Ikoyi, Lagos.

3. Collect your Nigerian Police Clearance Certificate and take it to your visa interview. The certificate should be ready in approximately two weeks, but - please - allow time for unforeseen delay.

Consulate General of the United States of America
P. O. Box 554
2, Walter Carrington Crescent, Victoria Island
Lagos, Nigeria

Date: _____

FOR THE EXAMINING PHYSICIAN:

EACH FORM OF-157 (FS-398) SHOULD BE ENDORSED BY THE PANEL PHYSICIAN AS FOLLOWS:

I certify that the person covered by this report is the bearer of Passport No._____

issued by _____ on _____

Dear Sir:

You are requested to perform a medical examination of _____ in accordance with provisions of "Technical instructions for Medical Examination of Aliens' of the United States Public Health Service, which is in your possession, and to report to results on the attached Form FS-398 (OF-157).

Please note that in accordance with Section 34.4 (pages 1-3) (pages 1-3) of the Technical Instructions cited above, neither a chest x-ray examination nor a serologic test for syphilis shall be required if the applicant is under the age of 15. A tuberculin test may be required, however, where there is evidence of contact with a known case of tuberculosis or other reason to suspect infection with tuberculosis. A serologic test may be required where there is a reason to suspect infection with syphilis.

X-Ray For Pregnant Women

A postponement of the chest x-ray of a pregnant female is permissible; however, it is the position of the United States Public Health Service that it is possible to perform safely the examination during pregnancy with proper shielding of the abdomen. It should be explained to the applicant that if the x-ray examination is postponed, the issuance of the immigrant visa will also be postponed until such time as the medical examination can be completed. Public Health Service regulations do not authorise a classification based only on a tuberculin skin test.

FOR THE APPLICANT:

VISA MEDICAL EXAMINATION

Information Sheet and Referral Letter

1. A medical examination is required of all applicants for immigrant visas. **NO APPLICANT WILL BE INTERVIEWED PRIOR TO THE RECEIPT OF THE RESULTS OF THE MEDICAL EXAMINATION AND TESTS.**

2. **Approved Examiners:** Medical examinations must be performed by physicians designated by the Embassy according to procedure prescribed by U.S. Law. The examining physicians are not employed by the U.S. Government.

3. **Fees:** Examination fees are paid by the applicant and are paid directly to the medical facility.

4. **Report of Examination:** The examining physician will either forward the completed report to the Embassy or hand it to you in a sealed envelope for presentation to the Consular Officer.

5. **Referral Procedure:** The following indicates the physician and institution by whom you must be examined. You only need to go to the location. Please provide the examiners *with 2 copies of your passport photograph.*

   Dr. K. A. Omotosho
   KAMORASS Specialist Clinics
   238A Muri Okunola Street
   Victoria Island
   Lagos.
   Tel: 01-2612799

6. **Hours of Examination:** A minimum of three working days must be allowed to complete the medical examination process. At times, the process may take longer than three days. Please not the following hours of examination:

Monday - Friday	8:00 a.m. - 5:00 p.m.
Saturdays	9:00 a.m. - 2:00 p.m.

Appointment times for the physical examination will be given during the first visit. The physical examination cannot be performed until the lab. test results are available. Please further note that you will be required to appear on two separate days - one day for x-rays and laboratory tests; another day for examination and results.

Procedure for Safeguarding Pregnant Women During X-Ray

The Bureau of Radiological Health, Food and Drug Administration and Public Health Service have provided the following information: "Non-abdominal examinations, when conducted with appropriate technique factors, collimation and abdominal shielding, contribute only negligible exposure to the embryo or fetus. (Collimation refers to adjustment by the operator of the size of the x-ray beam so that it is no larger than the film). With specific reference to ***chest x-rays,*** we have calculated the estimated radiation dose to the embryo or fetus for each type of 14 x 17 film (AP, PA and lateral). With adequate collimation, a single PA film delivers 0.09 millirad (mrad) to the embryo or fetus which is essentially negligible. This assumes that the operator adequately collimates the x-ray beam. Further assurances of protection can be achieved by requiring that the abdominal area of the women be shielded with a lead apron."

Doubtful Cases

Whenever further medical consultation is deemed advisable, the visa applicant should be referred to an appropriate specialist at the applicant's expense. Under generally accepted medical procedures, the specialist should report his findings and opinion to the Panel Physician who remains responsible for the completion of Form OF-157 (FS-398) and final results of the medical examination. In those comparatively rare instances where no specialist is available for consultation, Panel Physicians may refer specific problems to the Embassy which will in turn refer the case to the Public Health Service in the United States.

It is absolutely essential that any practitioner performing any part of this medical examination take proper care in identifying the applicant by comparison with his photograph. Special attention should be given to ensure that specimens submitted by the applicant are from the applicant and not a third party.

HIV TESTING

A blood test for antibody to the Human Immunodeficiency Virus (HIV) is required as part of your medical examination if you are age fifteen (15) or older. HIV is the virus that is the cause of the Acquired Immune Deficiency Syndrome(AIDS). AIDS is the name given to the group of illnesses which may occur in persons infected with HIV. Infection with HIV causes a defect in a persons natural immunity against disease. This defect leaves infected people vulnerable to serious illnesses that would not usually be a threat to anyone whose immune system was intact. This test is not to diagnose AIDS, but to detect antibodies to the virus. If the result is positive, it does not necessarily mean that you have AIDS or will get it.

The results of your test will be provided to a consular officer. Also, it may be necessary to report results to the health authorities in this country. A positive test result may mean that you will not be eligible to receive a visa. A positive test result could also have other local consequences on your day-to-day activities in the country.

U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

For use with TB Technical Instructions 1991 and the DS-3024

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Photo

Name *(Last, First, MI.)* _____, _____, _____

Birth Date *(mm-dd-yyyy)* _____ **Sex:** ☐ **M** ☐ **F**

Birthplace *(City/Country)* _____ / _____

Present Country of Residence _____ **Prior Country** _____

U.S. Consul *(City/Country)* _____ / _____

Passport Number _____ **Alien** *(Case)* **Number** _____

Date *(mm-dd-yyyy)* **of Medical Exam** _____ **Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____

Date Exam Expires *(6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy)* _____

Exam Place *(City/Country)* _____ / _____ **Panel Physician** _____

Radiology Services _____ **Screening Site** *(name)* _____

Lab *(name for HIV/syphilis/TB)* _____ / _____ / _____

(1) Classification *(check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(see Worksheets DS-3024, DS-3025 and DS-3026)*

☐ **Class A Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Human immunodeficiency virus (HIV)
- ☐ Hansen's disease, untreated multibacillary
- ☐ Addiction or abuse of specific* substance without harmful behavior
- ☐ Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ **Class B Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, noninfectious *(Class B1, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ TB, inactive *(Class B2, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
  See Section 4 on page 2 for TB treatment details
- ☐ Syphilis *(with residual deficit)*, treated within the last year
- ☐ Other sexually transmitted infections, treated within last year
- ☐ Current pregnancy, number of weeks pregnant _____
- ☐ Other *(specify or give details on checked conditions from worksheets)*
- ☐ Hansen's disease, treated multibacillary
  Treatment: ☐ Partial ☐ Completed
- ☐ Hansen's disease, paucibacillary
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ Sustained, full remission of addiction or abuse of specific* substances
- ☐ Any physical or mental disorder (excluding addiction or abuse of specific* substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

_____

_____

_____

(2) Laboratory Findings *(check all boxes that apply):*

Syphilis: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Titer 1	Notes
Screening			☐	☐		
Confirmatory			☐	☐		

Treated	If treated, therapy:	Date(s) treatment given *(3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose)*:E	

HIV: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Indeterminate	Notes
Screening			☐	☐	☐	
Secondary			☐	☐	☐	
Confirmatory			☐	☐	☐	

(3) Immunizations *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature _____ Panel Physician Signature _____ Date *(mm-dd-yyyy)* _____

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*

Medication	Dose/Interval *(i.e., mg/day)*	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's pre-treatment weight (kg) _____ Date *(mm-dd-yyyy)* _____

Remarks _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT

AUTHORITIES: The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE: The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES: If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.

U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*
NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
		Cardiology
☐	☐	Angina pectoris
☐	☐	Hypertension *(high blood pressure)*
☐	☐	Cardiac arrhythmia
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	History of tobacco use Current use ☐ Yes ☐ No
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease *(emphysema)*
☐	☐	History of tuberculosis *(TB)* disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No
		Neurology and Psychiatry
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder
☐	☐	Major impairment in learning, intelligence, self care, memory, or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
☐	☐	Use of drugs other than those required for medical reasons
☐	☐	Addiction or abuse of specific* substance *(drug)* *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
☐	☐	Other substance-related disorders *(including alcohol addiction or abuse)*
☐	☐	Ever taken action to end your life

No	Yes	
☐	☐	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
		Obstetrics and Sexually Transmitted Diseases
☐	☐	Pregnancy Fundal height _____ cm Last menstrual period Date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _____
		Endocrinology and Hematology
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease
☐	☐	History of malaria
		Other
☐	☐	Malignancy, specify _____
☐	☐	Chronic renal disease
☐	☐	Chronic hepatitis or other chronic liver disease
☐	☐	Hansen's Disease ☐ Multibacillary ☐ Paucibacillary Treated ☐ Yes ☐ No
☐	☐	Visible disabilities *(including loss of arms or legs)*, specify
☐	☐	Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ / ____ *(mmHg)* Heart rate _____ /min Respiratory rate ____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status
☐	☐	☐	Hearing and ears
☐	☐	☐	Eyes
☐	☐	☐	Nose, mouth, and throat *(include dental)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*
☐	☐	☐	Breast
☐	☐	☐	Lungs
☐	☐	☐	Abdomen *(including liver, spleen)*
☐	☐	☐	Genitalia *(including circumcision, infection(s))*
☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Lymph nodes
☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*

3. Additional Testing Needed Prior to Approving Medical Clearance

No	Yes	
☐	☐	Physical examination or laboratory results contradict medical history
☐	☐	Referral prior to departure If yes, provide results
☐	☐	Referral prior to departure If yes, provide results

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency *(Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form)*

☐ For continuing other treatment, specify

5. Remarks *(Describe any abnormal history, abnormal findings, and resulting interventions)*

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT

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PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.

U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

For use with TB TI 1991 and the DS-2053

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

Name *(Last, First, MI.)*	Age

Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (Case) Number

1. Chest X-Ray Indication *(Mark all that apply)*

- ☐ History of Tuberculosis *(TB)* Disease
- ☐ Contact with Person with TB
- ☐ TB Signs or Symptoms
- ☐ Adult *(With or without any of the other indications)*

(If child does not have any of the above, stop here.)

2. Chest X-Ray Findings **Date Chest X-Ray Taken** *(mm-dd-yyyy)* _____

- ☐ Normal Findings
- ☐ Abnormal Findings *(Indicate category and finding, checking all that apply, in the table below.)*

☐ **Can Suggest ACTIVE TB** *(Need smears)*	☐ **Can Suggest INACTIVE TB** *(Need smears if symptomatic)*	☐ **OTHER X-Ray Findings**
☐ Infiltrate or consolidation	☐ Discrete fibrotic scar or linear opacity *(fibrotic scar)*	☐ **Follow-Up Needed** *(Mark as "Class B Other")*
☐ Any cavitary lesion	☐ Discrete nodule*(s)* without calcification	☐ Musculoskeletal
☐ Nodule or mass with poorly defined margins *(such as tuberculoma)*	☐ Discrete linear opacity *(fibrotic scar)* with volume loss or retraction	☐ Cardiac
☐ Pleural effusion*	☐ Other *(Such as bronchiectasis)*	☐ Pulmonary, non-TB *(e.g., emphysema)*
☐ Hilar/mediastinal adenopathy with or without atelectasis		☐ Other
☐ Other *(Such as miliary findings)*		☐ **No Follow-Up Needed for** Pleural thickening, diaphragmatic tenting, calcified pulmonary nodule*(s)*, calcified lymph node*(s)*, calcified lymph nodes with calcified pulmonary nodule*(s)*, or minor musculoskeletal findings

* If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound.

Remarks

_____

_____

_____

Radiologist's Signature _____ Date Interpreted *(mm-dd-yyyy)* _____

3. Sputum Smears

☐ **No, Applicant has No Signs or Symptoms of TB and :**

- ☐ X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ OTHER X-Ray Findings Suggest **No Follow-Up Needed,** this is **No Class**
- ☐ X-Ray Normal, this is **No Class**

☐ **Yes, Applicant has** *(Mark all that apply)* :

- ☐ Signs or Symptoms of TB, See Section 1
- ☐ X-Ray Suggests ACTIVE TB, See Section 2

and Smear Results are:

Positive	Negative	Dates Obtained *(mm-dd-yyyy)*
☐	☐	_____
☐	☐	_____
☐	☐	_____

Sputum Smear Results and X-Ray:
At least One Smear Result POSITIVE and

☐ Any Chest X-Ray Finding *(Normal or Abnormal findings)*, this is **Class A/TB**

Three Smear Results NEGATIVE and

- ☐ X-Ray Normal with
  - ☐ Signs or Symptoms Resolved, this is **No Class**
  - ☐ Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ X-Ray Suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is **Class B Other**

4. ☐ **No Class** ☐ **Class A/TB** ☐ **Class B1/TB** ☐ **Class B2/TB** ☐ **Class B Other**

5. Follow-Up Needed After Arrival ☐ No ☐ Yes If Yes, for ☐ Not TB Condition ☐ TB Condition

Remarks *(If non-TB condition, specify condition below **and** on DS-2053 form; include additional tests, and therapy used with start and stop dates and any changes. If TB condition, enter information in Part 4 of DS-2053 form.)*

_____

_____

_____

_____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

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U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 or DS-2054 — To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 30 minutes
(See Page 2 of 2)

Name *(Last, First, MI.)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*		Alien (*Case*) Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available.

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record *(List Chronologically from Left to Right)* Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)*	Completed Series *(✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below: Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall *(Flu)* Season
Specify (*check*) vaccine: ☐ DT ☐ DTP ☐ DTaP											
Specify (*check*) vaccine: ☐ Td ☐ Tdap											
Specify (*check*) vaccine: ☐ Polio -OPV ☐ IPV											
Specify (*check*) vaccine: ☐ MMR (Measles-Mumps-Rubella) ☐ Rubella Specify (*check*) vaccine: ☐ Measles ☐ Measles - Rubella Specify (*check*) vaccine: ☐ Mumps ☐ Mumps - Rubella											
Rotavirus											
Hib											
Hepatitis A											
Hepatitis B											
Meningococcal											
Human papillomavirus											
Varicella											
Zoster											
Pneumococcal											
Influenza											

2. Results

☐ Vaccine History Incomplete

☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as Indicated Above)*.

☐ Applicant will request an individual waiver based on religious or moral convictions.

☐ Vaccine history complete for each vaccine, all requirements met *(Documented Above)*.

☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(Name)* _____

Panel Physician *(Signature)* _____

Date *(mm-dd-yyyy)* _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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